Reprinted
March 5, 1999

HOUSE BILL No. 1924

DIGEST OF HB 1924 (Updated March 4, 1999 2:46 pm - DI 88)

Citations Affected: IC 16-39; IC 22-3.

Synopsis: Medical records privacy. Provides that an employee has the right to examine and receive a copy of the employee's medical records. Provides a mechanism by which an employee may request and provide corrections to the employee's medical records. Requires that an entity possessing an employee's medical records not collect, use, or disclose the employee's personal health information except under certain circumstances. Requires the entity to keep a record of each disclosure of an employee's personal health information for five years. Provides circumstances under which an entity possessing an employee's medical records may disclose information contained in the medical records to a research organization without the employee's consent. Provides specific civil penalties that apply to an entity possessing an employee's medical records or to a research organization that knowingly or intentionally obtains an employee's personal health information or

(Continued next page)

Effective: July 1, 1999.

Cheney, Liggett, Dillon

January 26, 1999, read first time and referred to Committee on Human Affairs.
February 24, 1999, amended, reported — Do Pass.
March 4, 1999, read second time, amended, ordered engrossed.

Digest Continued

discloses an employee's personal health information to another person for reasons other than those provided by law. Provides certain information a billing review service must provide to a medical service provider if the medical service provider requests an explanation regarding the reduction of a bill. Allows the workers compensation board to fine a billing review service that does not comply with the law or that provides false information to a medical service provider.

Reprinted
March 5, 1999

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

HOUSE BILL No. 1924

A BILL FOR AN ACT to amend the Indiana Code concerning labor and industrial safety.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-39-1-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 10. In addition to the provisions of this article relating to the privacy of medical records in general, the provisions of IC 22-3-5.5 apply to the privacy of an employee's medical records in worker's compensation cases.**

SECTION 2. IC 22-3-3-5.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as

submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(4) The billing review standard shall include the billing charges of all hospitals in the applicable community for the service or product.

(b) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; ~~and~~

(4) in the case of a CPT coding change, the basis upon which the change was made; **and**

(5) upon request:

(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

(B) written certification from the billing review service that the billing review service complied with subsection (a) in the course of reviewing the medical service provider's bill;

not later than thirty (30) days after the date of the request.

(c) If, after a hearing, the workers compensation board finds that a billing review service:

(1) did not comply with subsection (a) or (b);

(2) under subsection (b)(5)(A) falsely identified the hospitals whose charges were included in the billing review standard used in the course of reviewing a medical service provider's bill; or

(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.

SECTION 3. IC 22-3-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 5.5. Worker's Compensation: Medical Records Privacy

Sec. 1. The provisions of this chapter apply in addition to the provisions relating to the privacy of medical records under IC 16-39.

Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Employee" means the:

(1) individual covered by this article; or

(2) individual's attorney or authorized union representative if the attorney or union representative has been given written authorization by the employee to act on the employee's behalf.

(c) "Personal health information" or "medical records" means information about an employee that relates to the following:

(1) The employee's health or health care history, including genetic information about the employee.

(2) Provision of health care to the employee.

(3) Payment for health care provided to the employee.

The term includes any identifying information that is collected in the course of the providing or paying for health care for the employee.

(d) "Trustee" means:

(1) a self insured employer;

(2) a worker’s compensation insurance company;

(3) a worker's compensation agency; or

(4) an employer (as defined in IC 22-3-6-1(a));

that collects or maintains personal health information.

Sec. 3. Whenever an employee is represented by an attorney or authorized union representative, a notice or copy required to be provided to the employee under this chapter must also be provided to the employee's attorney or authorized union representative upon request.

Sec. 4. An employee has a right, on request, to examine and receive a copy of the employee's personal health information that is maintained by a trustee.

Sec. 5. For purposes of accuracy or completeness, an employee may request, in writing, a correction of any personal health information that the employee believes is inaccurate.

Sec. 6. (a) A trustee who fails to make a requested correction under section 5 of this chapter to an employee's personal health information within thirty (30) days after receiving the request must:

(1) notify the employee in writing; and

(2) state one (1) or more reasons for the refusal.

(b) An employee who receives a notification under subsection (a) may file a statement of disagreement that includes the following:

(1) A description of the correction requested.

(2) The reason for the correction.

(c) Upon receiving a statement described in subsection (b), the trustee must add the statement to the employee's medical record.

Sec. 7. (a) A trustee shall:

(1) not collect, use, or disclose personal health information about an employee unless the information is for a lawful purpose connected with a function or activity of the trustee; and

(2) collect, use, or disclose only as much personal health information about an employee as is reasonably necessary to accomplish the purpose for which the personal health information is collected, used, or disclosed.

(b) Reasons for collecting, using, or disclosing an employee's personal health information include determinations of the following:

(1) A diagnosis of the employee's condition.

(2) Reasonable and necessary treatment for the employee's condition.

(3) The amount of time that the employee will be out of work.

(4) The relationship, if any, of the employee's condition to the employee's employment.

(5) Any work related restrictions resulting from the employee's condition.

(6) The kind of work for which the employee may be eligible.

(7) The anticipated time that the employee will be restricted.

(8) The permanent impairment, if any, resulting from the employee's condition.

(c) Other personal health information may be collected, used, or disclosed by the trustee only if authorized by the employee or by the employee's legal representative in writing, provided that the purpose for which the additional information is being sought has been revealed to the employee or the employee's legal representative.

Sec. 8. (a) A trustee may disclose personal health information without the consent of an employee only under the following conditions:

(1) The trustee reasonably believes that the disclosure is necessary to prevent or reduce a serious and immediate threat to:

(A) the employee; or

(B) public health or public safety.

(2) To provide a billing review organization with information needed to undertake periodic reviews of claims processing and payments.

(3) To assist in identifying a deceased employee.

(4) To inform the representative or a relative of a deceased employee, or any other individual the trustee considers reasonable to inform under the circumstances, of the employee's death.

(5) To conduct a peer review by health professionals.

(6) The disclosure is required by law for law enforcement purposes.

(b) A trustee may disclose information under subsection (a) only to the extent the recipient needs to know the information.

(c) A trustee shall keep a record of all disclosures made under this section for five (5) years.

Sec. 9. (a) A trustee may disclose an employee's personal health information without the employee's consent to research organizations conducting scientific, medical or public policy research.

(b) A trustee shall keep, for five (5) years after disclosing an employee's personal health information under subsection (a), a record of the research organizations to which the trustee discloses

protected personal health information.

(c) A trustee shall not disclose protected personal health information to a research organization unless the research organization agrees not to disclose the protected personal health information to a third person.

(d) A trustee shall disclose only the minimum data necessary to conduct the intended research.

(e) The trustee shall disclose protected personal health information only when the information is necessary to conduct the research.

Sec. 10. A research organization shall execute an agreement with the trustee that contains the following:

(1) A provision that it is unreasonable or impractical for the:

(A) person proposing the research; or

(B) trustee;

to obtain consent from an employee regarding the employee's personal health information.

(2) A requirement that the research project contain the following:

(A) Reasonable safeguards to protect the confidentiality and security of personal health information.

(B) Procedures to destroy the information or remove all identifying information at the earliest opportunity consistent with the purposes of the project.

(3) A provision that the personal health information requested will not be published in a form that could reasonably identify the employees concerned.

(4) A provision that the personal health information requested will be used only for the purposes of an approved research project.

(5) A provision that all individual identifiers will be removed before the publication or release of the research project.

Sec. 11. (a) The penalties described in subsection (b) apply to a trustee or research organization that knowingly or intentionally:

(1) obtains personal health information relating to an employee; or

(2) discloses personal health information to another person;

in violation of this chapter.

(b) Except as provided in subsection (c), a person described in subsection (a):

(1) commits a Class A misdemeanor; and

(2) in addition to any fine imposed under subdivision (1), may

be assessed a civil penalty by the worker's compensation board of not more than one hundred thousand dollars ($100,000).

(c) If a violation of this chapter is knowingly or intentionally committed:

(1) under false pretenses; or

(2) with the intent to sell, transfer, or use personal health information for commercial advantage, personal gain or malicious harm;

the person committing the violation may be assessed a civil penalty by the worker's compensation board of not more than two hundred fifty thousand dollars ($250,000).

SECTION 4. IC 22-3-7-17.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 17.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(4) The billing review standard shall include the billing charges of all hospitals in the applicable community for the service or product.

(b) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been

reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; ~~and~~

(4) in the case of a CPT coding change, the basis upon which the change was made; **and**

(5) upon request:

(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

(B) written certification from the billing review service that the billing review service complied with subsection (a) in the course of reviewing the medical service provider's bill;

not later than thirty (30) days after the date of the request.

(c) If, after a hearing, the workers compensation board finds that a billing review service:

(1) did not comply with subsection (a) or (b);

(2) under subsection (b)(5)(A) falsely identified the hospitals whose charges were included in the billing review standard used in the course of reviewing a medical service provider's bill; or

(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Human Affairs, to which was referred House Bill 1924, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 5, line 9, delete "hat" and insert "**that**".

Page 5, line 17, delete "Except as provided in subsections (c) and (d), a" and insert "**A**".

Page 5, line 22, delete "fifty" and insert "**one hundred**".

Page 5, line 22, delete "($50,000)" and insert "**($100,000)**".

Page 5, delete lines 23 through 42.

and when so amended that said bill do pass.

(Reference is to HB 1924 as introduced.)

SUMMERS, Chair

Committee Vote: yeas 11, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1924 be amended to read as follows:

Page 2, line 16, delete "health care professional" and insert "**self insured employer**".

Page 2, line 17, delete "health care facility" and insert "**worker's compensation insurance company**".

Page 2, line 18, after ";" insert "**or**".

Page 2, line 19, delete "or".

Page 2, delete line 20.

Page 2, line 25, after "representative" insert "**upon request**".

Page 5, line 17, delete "A" and insert "**Except as provided in subsection (c), a**".

Page 5, after line 22, begin a new paragraph and insert:

"**(c) If a violation of this chapter is knowingly or intentionally committed:**

(1) under false pretenses; or

(2) with the intent to sell, transfer, or use personal health information for commercial advantage, personal gain or malicious harm;

the person committing the violation may be assessed a civil penalty by the worker's compensation board of not more than two hundred fifty thousand dollars ($250,000).".

(Reference is to HB 1924 as printed February 25, 1999.)

CHENEY

HOUSE MOTION

Mr. Speaker: I move that House Bill 1924 be amended to read as follows:

Page 1, between lines 6 and 7, begin a new paragraph and insert:

"SECTION 2. IC 22-3-3-5.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under worker's compensation:

(1) The formation of a billing review standard, and any subsequent analysis or revision of the standard, must use data that is based on the medical service provider billing charges as

submitted to the employer and the employer's insurance carrier from the same community. This subdivision does not apply when a unique or specialized service or product does not have sufficient comparative data to allow for a reasonable comparison.

(2) Data used to determine pecuniary liability must be compiled on or before June 30 and December 31 of each year.

(3) Billing review standards must be revised for prospective future payments of medical service provider bills to provide for payment of the charges at a rate not more than the charges made by eighty percent (80%) of the medical service providers during the prior six (6) months within the same community. The data used to perform the analysis and revision of the billing review standards may not be more than two (2) years old and must be periodically updated by a representative inflationary or deflationary factor. Reimbursement for these charges may not exceed the actual charge invoiced by the medical service provider.

(4) The billing review standard shall include the billing charges of all hospitals in the applicable community for the service or product.

(b) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the medical service at the eightieth percentile; ~~and~~

(4) in the case of a CPT coding change, the basis upon which the change was made; **and**

(5) upon request:

(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

(B) written certification from the billing review service that the billing review service complied with subsection (a) in the course of reviewing the medical service provider's bill;

not later than thirty (30) days after the date of the request.

(c) If, after a hearing, the workers compensation board finds that a billing review service:

(1) did not comply with subsection (a) or (b);

(2) under subsection (b)(5)(A) falsely identified the hospitals whose charges were included in the billing review standard used in the course of reviewing a medical service provider's bill; or

(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.".

Page 5, after line 22, begin a new paragraph and insert:

"SECTION 4. IC 22-3-7-17.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 17.2. (a) A billing review service shall adhere to the following requirements to determine the pecuniary liability of an employer or an employer's insurance carrier for a specific service or product covered under this chapter:

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(A) the identity of each hospital whose billing charges were included in the billing review standard used in the course of reviewing the medical service provider's bill; and

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(3) under subsection (b)(5)(B) falsely certified compliance with subsection (a);

the workers compensation board may assess a civil penalty against the billing review service that is not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000) for each violation.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1924 as printed February 25, 1999.)

CROSBY